

Travis Unified School District Kaiser Permanente Plan Benefit Comparisons

Effective: January 1, 2024

Carrier Name	Kaiser HMO - \$10 Copay Closed to New Enrollment	Kaiser HMO - \$30 Copay	Kaiser Deductible HMO Not HSA Compatible \$10 copay	Kaiser HSA - \$1,800	Kaiser HSA - \$3,200	Kaiser Not HSA Compatible Bronze - \$4,500
General Plan Information						
Annual Deductible/Individual	\$0	\$0	\$500	\$1,800	\$3,200	\$4,500
Annual Deductible/Two-Party/Family	\$0	\$0	\$500/\$1,000	\$3,200/\$3,600	\$3,200/\$6,400	\$9,000
Office Visit/Exam/Outpatient Specialist Visit	\$10 copay	\$30 copay	\$10 copay no deductible	\$0 copay after deductible	\$0 copay after deductible	\$50 copay after deductible
Annual Out-of-Pocket Limit/Individual	\$1,500	\$1,500	\$3,000	\$3,600	\$3,200	\$6,000
Annual Out-of-Pocket Limit/Two-Party/Family	\$1,500/\$3,000	\$1,500/\$3,000	\$3,000/\$6,000	\$3,600/\$7,200	\$3,200/\$6,400	\$6,000/\$12,000
Outpatient Services						
Well-Child Care	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Immunizations	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Well Woman Exams	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Mammograms	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Adult Periodic Exams with Preventive Tests	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Diagnostic X-Ray and Lab Tests	\$0 copay	\$0 copay	\$10 copay after deductible	\$0 copay after deductible	\$0 copay after deductible	40% coinsurance after deductible
Pregnancy and Maternity Care (Pre-Natal Care)	\$0 copay	\$0 copay	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible	\$0 copay no deductible
Inpatient/Outpatient Hospital Services						
Inpatient Hospitalization	\$100 per admission	\$100 per admission	10% after deductible	\$0 copay after deductible	\$0 copay after deductible	40% coinsurance after deductible
Outpatient Facility Charge	\$10 copay	\$30 copay	10% after deductible	\$0 copay after deductible	\$0 copay after deductible	40% coinsurance after deductible
Emergency Services/Urgent Care						
Emergency Room	\$100 copay waived if admitted	\$100 copay waived if admitted	10% after deductible	\$0 copay after deductible	\$0 copay after deductible	\$250 copay after deductible (40% coinsurance if admitted)
Urgent Care Facility	\$10 copay	\$30 copay	\$10 copay no deductible	\$0 copay after deductible	\$0 copay after deductible	\$50 copay after deductible
Prescription Drug Benefits						
Retail Prescriptions						
Generic	\$10 copay	\$10 copay	\$10 copay no deductible	\$10 copay after deductible	\$0 copay after deductible	Deductible: \$250 \$15 copay no deductible
Brand (Formulary/Preferred)	\$30 copay	\$30 copay	\$30 copay no deductible	\$30 copay after deductible	\$0 copay after deductible	\$35 copay after drug deductible
Brand (Non-Formulary/Non-preferred)	\$30 copay	\$30 copay	\$30 copay no deductible	Same as Preferred Brand when approved through exception process	Same as Preferred Brand when approved through exception process	\$35 copay after drug deductible
Number of Days Supply	100 days	100 days	30 days	30 days	100 days	30 days
Mail Order Prescriptions						
Generic	\$10 copay	\$10 copay	\$20 copay no deductible	\$20 copay after deductible	\$0 copay after deductible	\$30 copay no drug deductible
Brand (Formulary/Preferred)	\$30 copay	\$30 copay	\$60 copay no deductible	\$60 copay after deductible	\$0 copay after deductible	\$70 copay after drug deductible
Brand (Non-Formulary/Non-preferred)	\$30 copay	\$30 copay	\$60 copay no deductible	Same as Preferred Brand when approved through exception process	\$0 copay after deductible	\$70 copay after drug deductible
Number of Days Supply for Mail Order	100 days	100 days	100 days	100 days	100 days	100 days
Specialty Prescriptions	20% coinsurance, not to exceed \$150/Rx (30 day supply)	20% coinsurance, not to exceed \$150/Rx (1-30 days)	20% not to exceed \$150/Rx (1-30 days)	\$50 copay after deductible; 30 day supply	\$0 copay after deductible; 30 day supply	\$70 copay after drug deductible 30% coinsurance, not to exceed \$150/Rx up to 30 day supply after drug deductible
Employee Premium - Less \$625 Employer Contribution						
SINGLE						
12 Months	\$836.33	\$711.70	\$440.19	\$231.57	\$199.44	\$77.60
11 Months	\$912.36	\$776.40	\$480.21	\$252.62	\$217.57	\$84.65
10 Months	\$1,003.60	\$854.04	\$528.23	\$277.88	\$239.33	\$93.12
TWO-PARTY						
12 Months	\$2,297.66	\$2,048.39	\$1,505.38	\$1,088.14	\$1,023.88	\$780.20
11 Months	\$2,506.54	\$2,234.61	\$1,642.23	\$1,187.06	\$1,116.96	\$851.13
10 Months	\$2,757.19	\$2,458.07	\$1,806.46	\$1,305.77	\$1,228.66	\$936.24
FAMILY						
12 Months	\$3,510.57	\$3,157.85	\$2,389.48	\$1,799.09	\$1,708.16	\$1,363.36
11 Months	\$3,829.71	\$3,444.93	\$2,606.71	\$1,962.64	\$1,863.45	\$1,487.30
10 Months	\$4,212.68	\$3,789.42	\$2,867.38	\$2,158.91	\$2,049.79	\$1,636.03

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